

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County <u>Greece</u>		8859	
Village or City <u>Port Deposit</u> (No.)			
2 FULL NAME <u>Oscar Allen</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Sept. 2</u> (Month) (Day) (Year)
8 DATE OF BIRTH <u>Sept. 21</u> (Month) (Day) (Year)	7 AGE <u>72 yrs. 11 mos. 19</u> ds. If LESS than 1 day, hrs. OR min. ?		
9 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Groom</u>		10 NAME OF FATHER <u>Benjamin Allen</u>	
11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		12 MAIDEN NAME OF MOTHER <u>Unknown</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>		14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Allen</u> (Address) <u>Port Deposit</u>	
15 Filed <u>9/3</u> , 19 <u>14</u> by <u>M. P. Barnes</u> <u>Port Deposit</u>		17 If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.	

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Sept. 2  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Aug 27, 1914, to Sept. 2, 1914,  
that I last saw him alive on Sept. 2, 1914,

and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
(Duration) yrs. mos. ds.

Contributory Port Deposit  
Secondary Edens

(Signed) G. H. Richards, M. D.  
Sept. 3, 1914 (Address) Port Deposit

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 PLACE OF BURIAL OR REMOVAL  
Loketbury County

DATE OF BURIAL  
Sept. 5, 1914

20 UNDERTAKER

ADDRESS  
J. A. Brummitt & Son, H. G. Grace

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 8 1914
BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 8860  
County Cecil

Village or City Fairfield (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Eva Anderson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Single

6 DATE OF BIRTH Marey 1st 1895  
(Month) (Day) (Year)

7 AGE 19 yrs 6 mos 16 ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Housework

## 9 BIRTHPLACE

(State or country) Maryland

## PARENTS

10 NAME OF FATHER John W. Anderson

11 BIRTHPLACE OF FATHER  
(State or country) Ra

12 MAIDEN NAME OF MOTHER Julee M Morrison

13 BIRTHPLACE OF MOTHER  
(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Julee M Harlan

(Address) Providence Ind

15 Filed Sept 18th 1914 Frank Fraser

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 16  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
191... to 191..., 191...

that I last saw h. alive on 191...

and that death occurred on the date stated above, at 191... m.

The CAUSE OF DEATH\* was as follows:

Cocaine Acid poisoning  
suicidal  
(Duration) 1 yra. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) Wm P. Dean Coroner  
Sept 16, 1914. (Address) Baltimore Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Blake

DATE OF BURIAL  
Sept 19, 1914

## 20 UNDERTAKER

L.D. Clements ADDRESS Cherry Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid housekeepers who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masculitis*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal*, *septicaemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *synsis*, *tetanus*) may be stated under the head of "Contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

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OCT 6 1914

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		8861	STATE OF MARYLAND CERTIFICATE OF DEATH		
County <u>Cecil</u>		Registration Dist. No. <u>94</u>			
Village or City <u>North East</u> (No.)		St. <u>Ward</u> )			
2 FULL NAME <u>Edward R Bailey</u>					[If death occurred in a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>March 24</u>		(Month)	(Day)	(Year) <u>1914</u>	
7 AGE <u>5 yrs.</u>		If LESS than 1 day, .... hrs. OR ..... min.?			
8 OCCUPATION <u>None</u>					
<ul style="list-style-type: none"> <li>(a) Trade, profession, or particular kind of work.</li> <li>(b) General nature of industry, business, or establishment in which employed (or employer)</li> </ul>					
9 BIRTHPLACE <u>Maryland</u> (State or country)					
10 NAME OF FATHER <u>Albert E Bailey</u>					
11 BIRTHPLACE OF FATHER <u>Bridgetown</u> (State or country)					
12 MAIDEN NAME OF MOTHER <u>Elizabeth Hall</u>					
13 BIRTHPLACE OF MOTHER <u>North East Md.</u> (State or country)					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>mrs Elizabeth Bailey</u> (Address) <u>North East Md.</u>					
15 Filed <u>Sept 7, 1914</u> by <u>Isaiah Bidle</u> Locality <u>Cecil</u> Registrar					
16 PLACE OF BURIAL OR REMOVAL <u>North East, Md.</u> DATE OF BURIAL <u>Sept 7, 1914</u>					
17 UNDERTAKER <u>H. M. Dunn</u> ADDRESS <u>North East Md.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

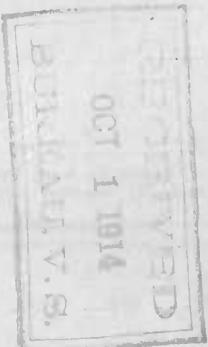
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchomycetoma* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "An-  
thema," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mares-  
mus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Tuberperial scrophulo-  
mia*," "*Tuberperial peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 1 1914

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		8862
County <u>Herrick</u>		<b>104</b>
Village or City <u>New Providence</u>		St. _____ Ward _____
2 FULL NAME <u>John Baranavitski</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Child</u>
6 DATE OF BIRTH <u>July 1st</u>		(Month) (Day) (Year) <u>1914</u>
7 AGE <u>2 21</u>	IF LESS than 1 day, ____ hrs. OR ____ min. ?	Yrs. <u>2</u> mos. <u>21</u> ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
PARENTS	10 NAME OF FATHER <u>Peter Baranavitski</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Russia</u>	
	12 MAIDEN NAME OF MOTHER <u>Mary Clumberg</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Russia</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Peter Baranavitski</u> (Address) <u>Childs Rd 1</u>		
15	Filed <u>Sept 22, 1914</u> By <u>Paul Frazer</u>	

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <u>Sept 20</u>	(Month) <u>Sept</u>	(Day) <u>20</u> , (Year) <u>1914</u>
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 12, 1914</u> , to <u>Sept 21, 1914</u> , that I last saw him alive on <u>Sept 21, 1914</u> , and that death occurred on the date stated above, at <u>1 P.M.</u>		
The CAUSE OF DEATH* was as follows: <u>Enteritis - Plethora</u>		
Contributory <u>Inflammation</u> Secondary		
(Duration) yrs. <u>1</u> mos. <u>15</u> ds.		
(Signed) <u>P. P. George</u>	(Duration) yrs. <u>1</u> mos. <u>15</u> ds.	(Address) <u>Cherry Hill</u>

\* State the DISEASE CAUSING DEATH, or, if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death	in the State	years months days
Where was disease contracted, if not at place of death?		
Former or usual residence.		

19 PLACE OF BURIAL OR REMOVAL <u>Elkton</u>	DATE OF BURIAL <u>Sept 21, 1914</u>
20 UNDERTAKER <u>L. A. Chernaty</u>	ADDRESS <u>Cherry Hill</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Horsewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) were symptoms or terminal conditions, such as "*Anesthesia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Delirium*" ("Con genital," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marsasmus*," "*Old Age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 6 1914

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		8863
County		<i>Cecil</i>
Village or City		<i>New Providence</i>
2 FULL NAME		
<b>PERSONAL AND STATISTICAL PARTICULARS</b>		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<i>Female</i>	<i>White</i>	<i>Child</i>
6 DATE OF BIRTH		<i>July 1st, 1917</i>
		(Month) (Day) (Year)
7 AGE	<i>7 yrs 20 mos</i>	
	If LESS than 1 day, .... hrs. OR min. ?	
8 OCCUPATION		
(a) Trade, profession, or particular kind of work.		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country)		
<i>Maryland</i>		
10 NAME OF FATHER		
<i>Peter Baranovikis</i>		
11 BIRTHPLACE OF FATHER (State or country)		
<i>Russia</i>		
12 MAIDEN NAME OF MOTHER		
<i>Mary Chuberg</i>		
13 BIRTHPLACE OF MOTHER (State or country)		
<i>Russia</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) <i>Peter Baranovikis</i>		
(Address) <i>Childs R. 91</i>		
15	<i>Sept 22, 1914 J. F. Mayer</i>	

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *92*

St.: Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

104

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 20, 1914*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 12, 1914* to *Sept 20, 1914*that I last saw him alive on *Sept 20, 1914*and that death occurred on the date stated above, at *11 P.M.*

The CAUSE OF DEATH\* was as follows:

*Enterocoecitis*

(Duration) yrs. mos. ds.

Contributory Secondary *Inascertian*

(Duration) yrs. mos. ds.

(Signed) *b. P. Beaman*, M. D. *Sept 21, 1914* (Address) *Cherry Hill*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Celton* DATE OF BURIAL *Sept 22, 1914*20 UNDERTAKER *J. J. Cleary* ADDRESS *Cherry Hill*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REGISTRAR

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDE, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sensus, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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BUJEAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

8864

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Port Deposit

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Minnie F. Bender

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
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6 DATE OF BIRTH

Feb 14, 1893  
(Month) (Day) (Year)

7 AGE

31 yrs. 7 mos. 10 ds.

If LESS than  
1 day.....hrs.  
OR.....min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife9 BIRTHPLACE  
(State or country)Maryland

## PARENTS

10 NAME OF FATHER

John Smith11 BIRTHPLACE OF FATHER  
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or country)11

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. F. Bender

(Address)

Port Deposit

15

Filed Sept. 26, 1914 J. R. Baumer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept - 24, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Sept 20, 1914, to Sept 24, 1914,that I last saw her alive on Sept 23, 1914,and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia Tuberculosis(Duration) 1 yrs. — mos. — ds.Contributory Exhaustion  
Secondary(Duration) 1 yrs. — mos. — ds.(Signed) Ernest Rosenthal, M. D.Sept 26, 1914 (Address) Liberty Grove Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death 1 yrs. 0 mos. 0 ds. In the State Md. yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Hopewell Cemetery DATE OF BURIAL Sept 26, 1914

20 UNDERTAKER

W C Jackson ADDRESS Blythedale Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

11

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*,

*Sarcoma*, *etc.*, of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dility" ("Congenital," "Seizile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 6 1914

BUREAU OF THE CENSUS

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Cecil</u>		8865	<del>EX-2</del>
Village or City <u>Elkton</u>		(No. <u>MD</u> )	
2 FULL NAME <u>Rachael Boulder</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDWED, OR DIVORCED (Write the word) <u>Married</u>	
6 DATE OF BIRTH <u>June 22</u>		(Month) <u>June</u>	(Day) <u>22</u>
		(Year) <u>1851</u>	
7 AGE <u>63 yrs 3 mos 7 ds.</u>		If LESS than 1 day,.....hrs. OR min. ? <u>—</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housework</u>			
(b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
10 NAME OF FATHER <u>Chas Wright</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>No information</u>			
12 MAIDEN NAME OF MOTHER <u>Felinda Chambers</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>No information</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Joe Simpers</u> (Address) <u>Elkton Md</u>			
15 Filed <u>Oct 2 1914</u>	<u>J. Frank Frazer</u> REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 29, 1914  
(Month) Sept (Day) 29 (Year) 1914

17 I HEREBY CERTIFY, That I attended deceased from January, 1914, to Sept. 29, 1914, that I last saw her alive on Sept. 27, 1914, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH\* was as follows:

Cancer of the cervix

(Duration) 2 yrs. mos. ds.

Contributory  
Secondary

(Duration) — yrs. mos. ds.

(Signed) D. D. Morrison, M.D.  
Sept 30, 1914. (Address) Elkton Md

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL  
Elkton Colored Cemetery DATE OF BURIAL  
Oct 2 1914

20 UNDERTAKER  
Vansinger & Sons ADDRESS  
Elkton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma

oma, *Sarcoma*, etc, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 6 1914

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil 8867  
19

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

Village or City Chesapeake

(No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Laura Christ

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)single

B DATE OF BIRTH

Aug. 30  
(Month) (Day), 1889  
(Year)

7 AGE

25 yrs — mos. 9 ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## B OCCUPATION

- (a) Trade, profession, or particular kind of work  
House work  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

New Jersey.

## PARENTS

## 10 NAME OF FATHER

Joseph Christ11 BIRTHPLACE OF FATHER  
(State or country)Pennsylvania

## 12 MAIDEN NAME OF MOTHER

Laura M. Evers13 BIRTHPLACE OF MOTHER  
(State or country)Pennsylvania

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Franklin  
(Address) 3rd Market St., Gloucester, N.J.

15 Filed 9/9, 1914 Glasgow  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 9<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191... to 191..., 191...,

that I last saw him ~~alive~~ dead before 11 a.m. 1914and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Intestinal Inflammation

(Duration) yrs. mos. ds.

Contributory  
SecondaryDrapery

(Duration) yrs. mos. ds.

(Signed) Wm P Dean CoronerSept 9<sup>th</sup>, 1914 (Address) Elkhorn, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. To the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Glasgow Sept 12, 1914  
DATE OF BURIAL

## 20 UNDERTAKER

John Clayton ADDRESS  
Chesapeake City  
Tid.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

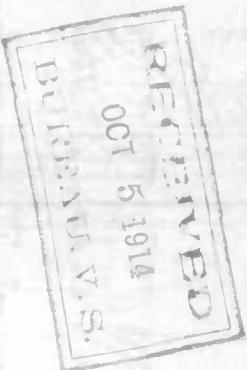
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County... Cecil

8868

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 93Village or City Chadds

(No.)

2 FULL NAME

Still Born Infant

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

Female White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Singler

6 DATE OF BIRTH

Sept 30, 1914

(Month) (Day) (Year)

7 AGE

Still Bornif LESS than  
1 day, hrs.  
yrs. mos. ds. OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment to  
which employed (or employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHERWm. S. Clark11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Wm. Clark(Address) Chadds Md

15

Filed....., 191.....

REGISTRAR

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 30, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191....., to ..... 191.....,

that I last saw h..... alive on ..... 191.....,

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory  
(Secondary)Prophes Twins

(Duration) yrs. mos. ds.

(Signed) O. S. Conner, M. D.Dept 30, 1914 (Address) Cherry Tree\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIEN-  
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place ..... in the  
of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL

Bouldens Chapel Oct 1st, 1914

20 UNDERTAKER

E. S. Grant ADDRESS Cherry Tree  
Ind

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocer*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

### Statement of cause of death—Name, first, the DISEASE

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma

*Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

8869

Dr. Jenkins

104

Village or City Elkton No. 2nd

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Horace J. Deibert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Apr

18, 1914  
(Month) (Day) (Year)

7 AGE

4 yrs 18 mos 18 ds If LESS than  
1 day, \_\_\_\_\_.hrs.  
OR \_\_\_\_\_.min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work. —
- (b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE

(State or country)

md

PARENTS

10 NAME OF FATHER

Hiram Deibert

11 BIRTHPLACE OF FATHER

(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Mary Seeds

13 BIRTHPLACE OF MOTHER

(State or country)

Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Deibert

(Address)

Elkton Md

15

Filed Sept 5, 1914 by Fraud Frazer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept

5

, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 23, 1914 to Sept 4, 1914  
that I last saw him alive on Sept 4, 1914

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH\* was as follows:

Enter- Colitis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Horace Jenkins, M. D.

1914 (Address) Elkton Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL  
Sept 6, 1914

20 UNDERTAKER

Vincent O'Brien

ADDRESS  
Elkton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congentital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	1910
OCT 6 1910	

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County..... *Cecil* 8870  
Village or City..... *Cecilton* (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *90*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Lucy Dorssey*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	Colored	X

6 DATE OF BIRTH  
3 31, 1914  
(Month) (Day) (Year)

7 AGE  
yrs. 51 mos. 18 ds. If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) *Cecil Co., Md.*

10 NAME OF  
FATHER *Unknown*

11 BIRTHPLACE  
OF FATHER  
(State or country) *Md.*

12 MAIDEN NAME  
OF MOTHER *Echel Dorssey*

13 BIRTHPLACE  
OF MOTHER  
(State or country) *Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jas. B. Balto*  
(Address) *Cecilton, Md.*

15 Filed *Sept 19, 1914 JAS Black*  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 18  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
*Sep 1, 1914, to Sep 18, 1914*,  
that I last saw her alive on *Sep 15, 1914*,

and that death occurred on the date stated above, at *3:45 p.m.*

The CAUSE OF DEATH\* was as follows:

*His Colitis*  
(Duration) yrs. 10 mos. 00 ds.

Contributory...  
Secondary

(Signed) *R. B. Black* (Duration) yrs. 00 mos. 00 ds.  
M. D. *Sep 18, 1914* (Address) *Cecilton, Md.*

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Cecilton* DATE OF BURIAL  
*9-19, 1914*

20 UNDERTAKER *S. A. Saxon* ADDRESS  
*Jas. Hall* *Cecilton*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gratfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of . . . . . (name origin); "Can-cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* injury, as fracture of skull, and consequences (e. g., *Sepsis*, *Tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Cecie

8871

105

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 90

Village or City Cecleton

(No.)

St. Ward)

## 2 FULL NAME

John G. Edwards

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED

Male Colored

Divorced  
(Write the word)

## 6 DATE OF BIRTH

(Month)

(Day)

1844  
(Year)

## 7 AGE

70 yrs.

mos.

ds.

It LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Frederick Moore,

(Address) Cecleton Md

## 15

Filed Sept. 5, 1914

J H Blaer  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sep. 3, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Aug 23, 1914, to Sep 3, 1914,

that I last saw him alive on Sep 2nd, 1914,

and that death occurred on the date stated above, at 2 P.M.  
The CAUSE OF DEATH\* was as follows:

Chronic Dysentery

(Duration) yrs. mos. ds.

Contributory  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) J H Blaer, M.D.

Sep. 6, 1914. (Address) Cecleton Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Cecleton  
Ag Green

## DATE OF BURIAL

Sep. 6, 1914

## 20 UNDERTAKER

ADDRESS  
Middletown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeeper*, who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

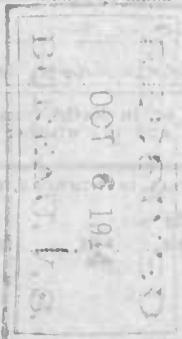
**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

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oma. Sarcoma, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmic," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 19



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <i>Bear</i>		8872	STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <i>Port Deposit</i> (No.)			Registration Dist. No. <i>96</i>		
2 FULL NAME <i>Percy Leroy Embly</i>			St. Ward)		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>MARRIED</i>	MEDICAL CERTIFICATE OF DEATH		
6 DATE OF BIRTH <i>Apr 17, 1881</i> (Month) (Day) (Year)			16 DATE OF DEATH <i>Sept - 15-, 1914</i> (Month) (Day) (Year)		
7 AGE <i>33 yrs. 4 mos. 28 ds.</i>	If LESS than 1 day, hrs. OR min. ?		17 I HEREBY CERTIFY, That I attended deceased from <i>Sept 13, 1914</i> to <i>Sept 13, 1914</i> , that I last saw <i>him</i> alive on <i>Sept 13, 1914</i> , and that death occurred on the date stated above, at <i>5 A.M.</i> The CAUSE OF DEATH* was as follows:		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Trolley Car Conductor</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Until health failed</i>			<i>Pulmonary Tuberculosis.</i>		
9 BIRTHPLACE (State or country) <i>Smithburg.</i>			Duration <i>5 yrs. 0 mos. 0 ds.</i>		
10 NAME OF FATHER <i>George T. Embly.</i>			Contributory (Secondary)		
11 BIRTHPLACE OF FATHER (State or country) <i>Franklin Co. Pa.</i>			(Signed) <i>Geo. T. Mason, M.D.</i>		
12 MAIDEN NAME OF MOTHER <i>Susan Honadle</i>			Address <i>Port Deposit, Md.</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Franklin Co. Pa.</i>			* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Mrs Matel Embly.</i>			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.		
(Address) <i>Port Deposit, Md.</i>			Where was disease contracted, if not at place of death?		
15 Filed <i>Sept. 16, 1914</i> by <i>A.C. Laumann</i>			Former or usual residence.		
Corporating REGISTRAR			19 PLACE OF BURIAL OR REMOVAL <i>West Nottingham Fund Cemetery</i> Sept. 18, 1914		
			DATE OF BURIAL		
			20 UNDERTAKER <i>Slater &amp; Ich</i> ADDRESS <i>Colona Md</i>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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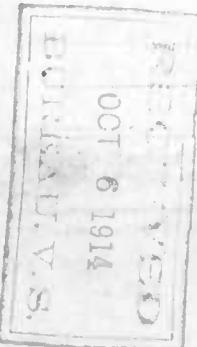
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Surcoma

etc. of \_\_\_\_\_ (name origin: "Can-  
cer" is less definite; avoid use of "Tumor" for malignant  
neoplasms); *Measles*; *Whooping cough*; *Chronic  
valvular heart disease*; *Chronic interstitial nephritis*,  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Ex-  
ample: *Masles* (disease causing death), 29 d.;  
*Bronchopneumonia* (secondary), 10 d. Never report  
mere symptoms or terminal conditions, such as "As-  
thenia," "Anaemia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Mara-  
nus," "Old Age," "Shock," "Uraemia," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage, as "Puerperal septicar-  
mia," "Puerperal peritonitis," etc. State cause for  
which surgical operation was undertaken. For vio-  
lent deaths state means of injury and qualify as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably  
such, if impossible to determine definitely. Examples:  
Accidental drowning; Struck by railway train—acci-  
dent; Revolver wound of head—homicide; Poisoned  
by carbolic acid—probably suicide. The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
scpsis, tetanus) may be stated under the head of  
"Contributory." (Recommendations on statement of  
cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-  
tions answered in detail, it will prevent further correspond-  
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OCT 6 1914

RECEIVED U. S. GOVERNMENT

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County.....		8873.
Village or City.....		North East (No.)
2 FULL NAME..... James Price Foraker		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX male	4 COLOR OR RACE white	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married
6 DATE OF BIRTH July 31 <sup>st</sup>		(Month) (Day) (Year)
7 AGE 32 yrs. 1 mos. 15 ds.	If LESS than 1 day, .... hrs. OR ..... min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work..... Liveryman		
(b) General nature of Industry, business, or establishment in which employed (or employer) .....		
9 BIRTHPLACE (State or country) Cecil Co. Md.		
10 NAME OF FATHER James R. Foraker		
11 BIRTHPLACE OF FATHER (State or country) Cecil Co. Md.		
12 MAIDEN NAME OF MOTHER Lydia Logan		
13 BIRTHPLACE OF MOTHER (State or country) Cecil Co. Md		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Louise A. Mahoney (Address) North East, Md.		
15 Filed Sept 17, 1914 Deed B. dealee (Signature) Lucas REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St. Ward

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Sept 10, 1914, to Sept 15, 1914,

that I last saw him alive on Sept 15, 1914,  
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

Hyphuric Fever  
Probably fits weak (Duration) yrs. mos. ds.

Contributor  
(Secondary)

(Duration) yrs. mos. ds.  
(Signed) Wm. C. Muller, M.D.

Sept 17, 1914 (Address) North East

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL North East DATE OF BURIAL  
Sept 18, 1914

20 UNDERTAKER H. M. Pierson ADDRESS  
North East

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

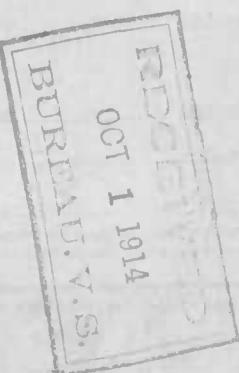
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mechitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Intrauterine septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <i>Cecil</i>		8874
Village or City <i>Bay View</i> (No.)		64
2 FULL NAME <i>William Reed Gamble</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WOOED, OR DIVORCED (Write the word) <i>married</i>
6 DATE OF BIRTH <i>November 16</i> (Month) <i>Nov.</i>		1844 (Year)
7 AGE <i>69 yrs. 10 mos. 21 ds.</i>	If LESS than 1 day, ... hrs. OR ... min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Farmer</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i></i>		
9 BIRTHPLACE (State or country) <i>Cecil Co Md</i>		
10 NAME OF FATHER <i>John Gamble</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Ireland</i>		
12 MAIDEN NAME OF MOTHER <i>Nancy Burns</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Cecil Co Md</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Lavinia A. Gamble</i> (Address) <i>North East R. P. #1 Md</i>		
15 Filed <i>Sep 23 1914</i>	I if more blanks are needed, address State Registrar, 6 E. Franklin St. Balt., Requesting V. S. No. 1.	

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *94*

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 21, 1914*  
(Month) *Sept* (Day) *21* (Year) *1914*

17 I HEREBY CERTIFY, That I attended deceased from *May 24, 1914* to *Sept 21, 1914*, that I last saw him alive on *Sept 21, 1914*, and that death occurred on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy*  
Contributory (Secondary) *Chronic Intestinal Inflammation*  
(Duration) yrs. mos. *3* ds.  
(Signed) *W. L. Gamble*, M. D.  
*Sep 23, 1914* (Address) *Baltimore, Maryland*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

*Bayview Md* DATE OF BURIAL *Sept 24, 1914*

20 UNDERTAKER *J. M. Pierson*

ADDRESS

*North East Md*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

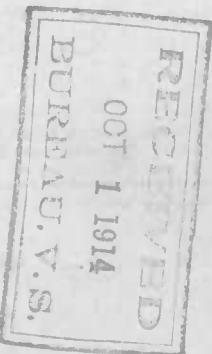
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcin-*

oma

oma. Sarcoma, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Ex. example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæsthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil  
8875  
Village or City Elkton (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. Gor

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME  
Ronald A. Gary

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
-------------------	------------------------------	---

6 DATE OF BIRTH July 2, 1913  
(Month) (Day) (Year)

7 AGE 1 yrs 2 mos 16 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. —  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF FATHER Walter Gary

11 BIRTHPLACE OF FATHER  
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertude Plummer

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Gertude Gary  
(Address) Elkton Md

15 Filed Sept. 19, 1914 J. Frank Frazer  
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1914, to Sept. 18, 1914,

that I last saw him alive on Sept. 17, 1914,

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH\* was as follows:

Gastro-entero-colitis.

(Duration) — yrs. — mos. — ds.

Contributory  
Secondary

(Signed) H. Arthur Mitchell (Duration) — yrs. — mos. — ds.  
, M.D.

Sept. 19, 1914. (Address) Elkton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

## DATE OF BURIAL

Sept. 20, 1914

## 20 UNDERTAKER

Vinson & Pippin

## ADDRESS

Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH 8876

County Cecil

Village or City North East (No.)

<sup>2</sup>FULL NAME Berichel L Goodnow

PERSONAL AND STATISTICAL PARTICULARS		
<sup>3</sup> SEX Male	<sup>4</sup> COLOR OR RACE White	<sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

<sup>8</sup> DATE OF BIRTH June 5, 1914  
(Month) (Day) (Year)

<sup>7</sup> AGE yrs. 3 mos. 5 ds. It LESS than  
1 day, hrs.  
OR min. ?

<sup>8</sup> OCCUPATION (a) Trade, profession, or particular kind of work... None  
(b) General nature of industry, business, or establishment in which employed (or employer) ...

<sup>9</sup> BIRTHPLACE (State or country) Cecil County Md

<sup>10</sup> NAME OF FATHER Edward R Goodnow

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Cecil County Md

<sup>12</sup> MAIDEN NAME OF MOTHER Annie Jones

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Cecil County Md

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Edward R Goodnow Md

(Address) North East

<sup>15</sup> Filed Sept 11, 1914 Deceased Biddele  
Cecil REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

104

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Sept 9, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from Sept 7, 1914, to Sept 9, 1914, that I last saw him alive on Sept 9, 1914, and that death occurred on the date stated above, at 7 P.M. The CAUSE OF DEATH\* was as follows:

Cholera Infantum

(Duration) 0 yrs. 6 mos. 2 days

Contributory  
(Secondary)

(Duration) yrs. mos. days  
(Signed) W. E. C. (Address) 1914, M. D. 1914, Nutent

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

<sup>19</sup> PLACE OF BURIAL OR REMOVAL North East  
DATE OF BURIAL Sept 12, 1914

<sup>20</sup> UNDERTAKER W. M. Pierson  
ADDRESS North East

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

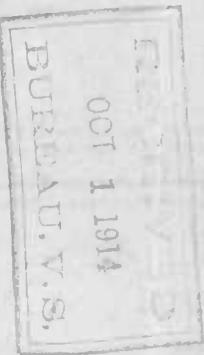
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcin-*

oma

*Sarcoma*, etc. of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Tuerperal septicæmia*," "*Tuerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County *Cecil*

8877

Village or City *Near Earleville*

(No.)

2 FULL NAME

*Elizabeth Gool*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Colored

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

6 23  
(Month) (Day) 1914  
(Year)

7 AGE

yrs. 28 mos. 26 ds.

If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Walter Gool*

15

(Address) *Earleville Md*Filed *Sept 18, 1914 J.W. Black*

Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *90*

St. Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9 17  
(Month) (Day) , 1914  
(Year)17 I HEREBY CERTIFY, That I attended deceased from  
*Sep 1, 1914*, to *Sep 10/13, 1914*,that I last saw her alive on *Sep 13, 1914*and that death occurred on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Malaria**Rev R Dean Sonnen Chtn*  
(Duration) yrs. mos. ds.Contributory  
Secondary*Gastric Distention*  
(Duration) yrs. mos. ds.(Signed) *R. McSwell*, M. D.*9/18, 1914* (Address) *Warwick Md.*\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place \_\_\_\_\_ yrs. mos. ds. In the  
of death \_\_\_\_\_ yrs. mos. ds. State \_\_\_\_\_ yrs. mos. ds.Where was disease contracted,  
It not at place of death?Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

*Poole Neck Cem.* DATE OF BURIAL  
*Sept 18, 1914*

20 UNDERTAKER

*J. Coffey* ADDRESS  
*Cecil Co. Md.*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm labore, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*,

*Oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic arteriolar heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Revolver wound of heart—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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## MARGIN RESERVED FOR BINDING

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V. S. No. 1.

1 PLACE OF DEATH

County Cecil

8878

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

Village or City Chesapeake

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry Benjamin Hale

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Jan

6 (Month) (Day)

1, 914 (Year)

7 AGE

8 yrs

6 mos.

If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Chesapeake City

## PARENTS

10 NAME OF FATHER

Harry J. Hale

11 BIRTHPLACE OF FATHER

(State or country)

to Elizanne

12 MAIDEN NAME OF MOTHER

Myrtle Hempfie

13 BIRTHPLACE OF MOTHER

(State or country)

Mary Land

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hattie Rey notes

15

Filed 9/14, 1914(Address) Chesapeake City

REGISTRAR

104

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept

12th

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 24th, 1914, to Sept 12th, 1914.that I last saw him alive on Sept 12th, 1914.and that death occurred on the date stated above, at 2-30 P.M.

The CAUSE OF DEATH\* was as follows:

Enter - colitis following  
intestinal indigestion  
which probably had been present  
since birth (Duration) yrs. mos. ds.Contributory Enter - colitis  
Secondary

(Duration) yrs. mos. ds.

(Signed) E. H. Wiley M. D.  
Sept 13th, 1914 (Address) Chesapeake City

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ in the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Where was disease contracted,  
If not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Bethel Cemetery

DATE OF BURIAL

Sept 15, 1914

20 UNDERTAKER

John C. Lupfer

ADDRESS

Chesapeake City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

H

Ind

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal minc*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., scaphis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

<b>RECEIVED</b>
OCT 5 1914
BUREAU, V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil . 8879

Village or City Baltimore, Md. No. 120

2 FULL NAME Annie Henry

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) widow

6 DATE OF BIRTH X X, 1844  
(Month) (Day) (Year)

7 AGE 70 yrs. — mos. — ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work Servant.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Housewife.

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF  
FATHER Robert Tilghman

11 BIRTHPLACE  
OF FATHER  
(State or country) Maryland

12 MAIDEN NAME  
OF MOTHER Judia Lewis

13 BIRTHPLACE  
OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Lynd Tilghman

(Address) Baltimore, Md.

Filed Sept 11, 1914 S. Sawelle  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 91

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH Sept 10<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
July 25<sup>th</sup>, 1914, to Sept 10<sup>th</sup>, 1914,  
that I last saw her alive on Sept 10<sup>th</sup>, 1914  
and that death occurred on the date stated above, at 3-20 P.M.  
The CAUSE OF DEATH\* was as follows:

Bright's Disease  
was failing something  
before calling medical aid  
don't know  
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
(Secondary) Dropsy  
do not know  
(Duration) 1 yrs. 0 mos. 0 ds.  
(Signed) S. H. Wilsey M. D.  
Sept 11, 1914 (Address) Chesapeake City

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
It not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Bohemia Manor DATE OF BURIAL  
Sept 13, 1914

20 UNDERTAKER Charles C. Banks ADDRESS  
Chesapeake City, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., or \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—*accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 5 1914

BUREAU, V.S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

8880

28

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 93Village or City Cherry Hill2 FULL NAME Oliver J. Dm Hoff

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
-------------------	------------------------------	---

6 DATE OF BIRTH

May 25, 1895  
(Month) (Day) (Year)

7 AGE

39 yrs. 4 mos. 0 ds.If LESS than  
1 day, ... hrs.  
OK min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) Penn

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed , 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 30, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That attended deceased from

June 1914 to Sept 30, 1914that I last saw him alive on Sept 29, 1914

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 9 mos. - ds.

Contributory  
(Secondary)Exhaustion

(Duration) yrs. mos. - ds.

(Signed) O. J. Conner, M. D.Sept 30, 1914 (Address) Cherry Hill

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Cherry HillDATE OF BURIAL  
Oct. 3, 1914

20 UNDERAKER

C. S. Conner

ADDRESS

Cherry Hill Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

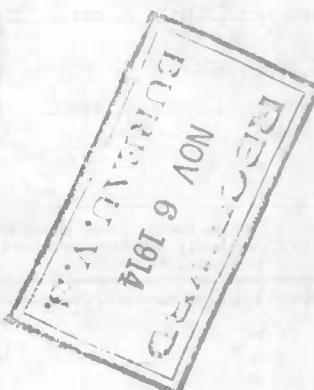
Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: "Accidental drowning"; "Struck by railway train—accident"; "Revolver wound of head—homicide"; "Poisoned by carbolic acid—probably suicide." The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <i>Baltimore</i>		8881	31
County			
Village or City	<i>Port Deposit</i>		
2 FULL NAME <i>Joseph Jones</i>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>Male</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) <i>Defaut</i>	6 DATE OF BIRTH <i>Aug - 7 - 1914</i> (Month) (Day) (Year)
7 AGE yrs. ....	mos. ....	ds. ....	If LESS than 1 day, ..... hrs. OR min. ? <i>31</i>
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Defaut</i> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <i>Baltimore, Md.</i>			
10 NAME OF FATHER <i>William Pierce</i>			
11 BIRTHPLACE OF FATHER (State or country) <i>Baltimore, Md.</i>			
12 MAIDEN NAME OF MOTHER <i>Annie Jones</i>			
13 BIRTHPLACE OF MOTHER (State or country) <i>Baltimore, Md.</i>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Edith Jones</i> (Address) <i>204 St. Rep. Rd.</i>			
15 Filed <i>Sept. 9, 1914</i>	16 St. R. Roamerow	REGISTRAR	17 DATE OF BURIAL <i>Sept. 9, 1914</i>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, MD, Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *96*

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*Sept - 7 - 1914*  
Month (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
*Aug 7 - 1914* to *Sept 1 - 1914*  
that I last saw him alive on *Sept 1 - 1914*

and that death occurred on the date stated above, at *5.1 m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Syphilis*

(Duration) yrs. mos. ds. *31*

Contributory  
Secondary

(Signed) *John Ferguson* (Duration) yrs. mos. ds. *M. D.*  
*Sept 7 - 1914* (Address) *Baptist Part 1*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL  
*Baltimore County* DATE OF BURIAL  
*Sept. 9, 1914*

20 UNDERTAKER  
*Joseph Jones* ADDRESS  
*Port Deposit, Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

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*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

8882

County BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Colona (No.)2 FULL NAME Nora M. Krauss

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Aug 30</u>		(Month) (Day) (Year) <u>, 1914</u>
7 AGE <u>— yrs. — mos. — ds.</u>		If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Hair Infant</u>	
(b) General nature of industry, business, or establishment in which employed (or employer)	

9 BIRTHPLACE (State or country) <u>Baltimore Md</u>	
10 NAME OF FATHER <u>Eleanor H Krauss</u>	
11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore Md</u>	
12 MAIDEN NAME OF MOTHER <u>Myrtle Nickle</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore Md</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clarance Krauss</u>	
(Address) <u>Colona Md</u>	

15 Filed <u>Sept 30, 1914</u>	St. P. Commissioner <u>John J. O'Connor</u>
REGISTRAR	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 29  
(Month) (Day) (Year) , 1914

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1914, to Sept 29, 1914, that I last saw her alive on Sept 28, 1914, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH\* was as follows:

Cholera - manufacture

(Duration) yrs. — mos. 7 ds.  
Contributory (Secondary) Exhaustion

(Duration) yrs. — mos. ds.  
(Signed) Ernest Rowland, M. D.  
Sept 29, 1914 (Address) Liberty Medical

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL West Nottingham Cemetery DATE OF BURIAL Sept 30, 1914

20 UNDERTAKER John B. Tash ADDRESS Colona Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write None.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritonaeum, etc. Carbuncle

oma. Surgeon, etc., of \_\_\_\_\_ (name origin); "Captain" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

Cecil

8883

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

Village or City

Elkton Union Hospital  
(No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Sarah L. Lewis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
*(Write the word)*

Single

6 DATE OF BIRTH

— (Month) — (Day), 1844 (Year)

7 AGE

74

yrs.

mos.

ds.

If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Md

## 10 NAME OF FATHER

Mrs. Lewis

## 11 BIRTHPLACE OF FATHER

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Sarah Aldridge

## 13 BIRTHPLACE OF MOTHER

(State or country)

Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. A. Brown

(Address)

Elkton Md

15

Filed Sept 19, 1914

of Francis Frazer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 16<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 24, 1914, to Sept 16, 1914,

that I last saw her alive on Sept 16, 1914,

and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH\* was as follows:

Cancer of the Colon

Indefinite (Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Howard Brannon, M.D.  
Sept 18, 1914. (Address) Elkton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL  
Sept 19, 1914

## 20 UNDERTAKER

Vinsonga Lippis

ADDRESS  
Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer-Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchomycetoma* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ailment," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *synsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 6 1914

BUREAU. V. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County.....  
Village or City.....

8884

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME.....

Rising Sun  
Helen R. McCoy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX  
Female

4 COLOR OR RACE  
White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)  
Single

6 DATE OF BIRTH  
March 24, 1864

(Month) (Day) (Year)

7 AGE  
50 yrs. 5 mos. 18 ds.  
It LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work  
Milliner

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)  
Dublin-Harford Co. Md.

10 NAME OF  
FATHER  
Richard B. McCoy

11 BIRTHPLACE  
(State or country)  
Balto. Maryland

12 MAIDEN NAME  
OF MOTHER  
Nancy Salbreath

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  
David L. McCoy

(Address)  
Oxford, Pa.

15  
Eld. 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
9 - 11, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

3 mo. 28th, 1914, to 9 mo. 10th, 1914,

that I last saw her alive on Sept. 10th, 1914,

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH\* was as follows:

Paralysis.

(Duration) yrs. 5 mos. 14 ds.

Contributory Acute Uremia  
(Secondary)

(Duration) yrs. mos. 4 ds.

(Signed) Geo. J. Ware, M. D.

9/11, 1914 (Address) Rising Sun

State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL  
ScotsvilleDATE OF BURIAL  
9/14, 191420 UNDERTAKER  
Taylor & FiegelADDRESS  
Rising Sun

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

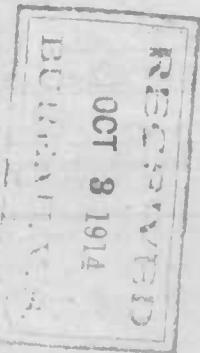
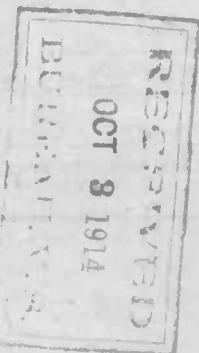
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Nurses* or *Maids* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcinoma*, *Sarcoma*, etc. of \_\_\_\_\_ (name origin); "Can-zer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-asmus," "Old Age," "Shock," "Trama," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver round of hand—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8885  
Cecil County  
Village or City near Elkton (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 92

St: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Eliza Emma Maxwell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
F	W.	single

6 DATE OF BIRTH Aug 9, 1914  
(Month) (Day), (Year)

7 AGE  
1 yrs. 1 mos. 21 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.....  
none  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer).....

9 BIRTHPLACE  
(State or country) Md

10 NAME OF  
FATHER Walter C. Maxwell

11 BIRTHPLACE  
OF FATHER  
(State or country) Del.

12 MAIDEN NAME  
OF MOTHER Mary S. Scatter

13 BIRTHPLACE  
OF MOTHER  
(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Walter C. Maxwell  
(Address) Elkton Md (P. O. D.)

15 Filed Oct 2, 1914, by Frank Drayton  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Aug 1, 1914, to Sept 1, 1914  
that I last saw her alive on Sept 16, 1914  
and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:

Cocculitis.  
Endocarditis  
Pneumonia  
Duration \_\_\_\_\_ mos. ds.

Contributory  
(Secondary)

(Signed) H. G. W. M. D.  
Oct 1, 1914 (Address) Newark Del.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL White Clay Creek, Del. DATE OF BURIAL Oct 3, 1914

20 UNDERTAKER E C Wilson ADDRESS Newark Del.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pianist*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vascular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapsus," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUKLEY	OCT 6 1914
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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**  
County Cecil

8886

104

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City North East (No.)**2 FULL NAME** Everett Townsend Nelson

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
<u>Male</u>	<u>white</u>	<u>Single</u>

**6 DATE OF BIRTH**June 9, 1914  
(Month) (Day) (Year)**7 AGE**0 yrs. 3 mos. — ds.It LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?**8 OCCUPATION**(a) Trade, profession, or  
particular kind of workNone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)**9 BIRTHPLACE**  
(State or country)Cecil County, Md.**10 NAME OF FATHER**Earl S. Nelson**11 BIRTHPLACE OF FATHER**

(State or country)

Wilmington, Del.**12 MAIDEN NAME OF MOTHER**Myrtle Lynch**13 BIRTHPLACE OF MOTHER**

(State or country)

Cecil Co., Md.**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**(Informant) Myrtle Nelson(Address) North East, Md.**15**Filled Sept 9, 1914 at Balto. Local

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**Sept 7, 1914  
(Month) (Day) (Year)**17** I HEREBY CERTIFY, That I attended deceased fromJune 9, 1914, to Sept 7, 1914,  
that I last saw him alive on Sept 7, 1914,and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH\* was as follows:

Malaria(Duration) — yrs. 3 mos. — ds.Contributory  
SecondaryGastric Enteritis(Duration) — yrs. 5 mos. 5 ds.(Signed) Sept 9, 1914 (Address) North East, Md.Wilmington(Duration) — yrs. 5 mos. 5 ds.North East, Md.North East, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ in the \_\_\_\_\_

at death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,

If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL North East, Md.DATE OF BURIAL Sept 9, 191420 UNDERTAKER J. M. PiersonADDRESS North East, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

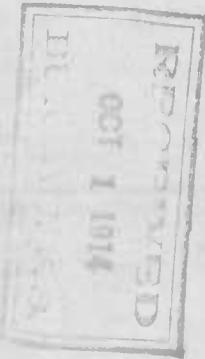
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite): Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for white surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County *Cecil*

8887

92

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *90*Village or City *Near Earleville* (No.)

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *May V. Miles*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>female</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Widow</i> (Write the word)
---------------------	--------------------------------	--

## 6 DATE OF BIRTH

*4 3, 1895*  
(Month) (Day) (Year)

## 7 AGE

*19 yrs. 6 mos. 16 ds.*  
It LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) *House Work*

## 9 BIRTHPLACE

(State or country) *Cecil Co., Md.*

## 10 NAME OF FATHER

*Philip Wilson*

## 11 BIRTHPLACE OF FATHER

(State or country) *Cecil Co., Md.*

## 12 MAIDEN NAME OF MOTHER

*Margurite Brooks*

## 13 BIRTHPLACE OF MOTHER

(State or country) *Cecil Co., Md.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Philip Wilson*(Address) *Earleville, Md.*

## 15

Filed *Sept 21, 1914 J H Black*  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *9 20, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from *Sep 16, 1914* to *"*, 1914,  
that I last saw him alive on *Sep 16, 1914*

and that death occurred on the date stated above, at *6 a.m.*  
The CAUSE OF DEATH\* was as follows:

*Labor Pneumonia*

(Duration) yrs. mos. ds.  
Contributory Secondary *Child birth*

(Signed) *J H Black*, M. D.  
Sep 21, 1914. (Address) *Clinton, Md.*

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL *Paplan Neck Cem* DATE OF BURIAL *Sept 22, 1914*

20 UNDERTAKER *John P. Coffey* ADDRESS *Cecil Co., Md.*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin), "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 6 1914

BUREAU, V. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil  
Village or City Perryville (No.)

8888

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bessie Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Marsied

## 6 DATE OF BIRTH

May 26, 1882  
(Month) (Day) (Year)

## 7 AGE

32 yrs. 3 mos. 8 ds.

if LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer) Housework

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER

Harford Co Md  
Charles W. Cannon

11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cassie W. Cannon

(Address)

Street Harford Co Md

## 15

Filed 7/3

1916

McCormick

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 3, 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Sept 3, 1916, to Sept 8, 1916,

that I last saw h er alive on Sept 8, 1916,  
and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH\* was as follows:

Heart DiseaseDied Suddenly

(Duration) yrs. mos. ds.

Contributory Art. 1  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Geo W. Cannon, M. D.  
Sept 3, 1916 (Address) Perryville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds. in the \_\_\_\_\_ State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL  
Dublin Cemetery DATE OF BURIAL  
Sept 5, 1916

## 20 UNDERTAKER

ADDRESS  
W C Jackson Blythedale

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Cecil</u>		8889	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>near Principia Furnace</u>		104	Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Howard J. Buckle</u>		St.: _____ Ward)	[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>April 9, 1914</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Sept-17, 1914</u> (Month) (Day) (Year)		
7 AGE <u>5 yrs. 8 mos. 8 ds.</u>		17 I HEREBY CERTIFY, That I attended deceased from <u>Grace</u> , 1914, to <u>Sept 17, 1914</u> , that I last saw him alive on <u>Sept 16, 1914</u> , and that death occurred on the date stated above, at <u>4 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Stroke</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		(Duration) <u>3 yrs. 3 mos. 3 ds.</u>		
9 BIRTHPLACE (State or country) <u>Cecil Co Md</u>		Contributory <u>Sentences</u> Secondary		
10 NAME OF FATHER <u>Clyde Buckle</u>		(Duration) <u>Mr. W. H. King</u> (Signed) <u>Sept 17, 1914</u> (Address) <u>Principia Furnace</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Cecil Co Md</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
12 MAIDEN NAME OF MOTHER <u>Bessie Craig</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death, _____		
13 BIRTHPLACE OF MOTHER (State or country) <u>Cecil Co Md</u>		Former or usual residence _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clyde Buckle</u> (Address) <u>Principia Furnace</u>		19 PLACE OF BURIAL OR REMOVAL <u>Asbury Cemetery</u> DATE OF BURIAL <u>Sept 19, 1914</u>		
15 Filed <u>Sept 18, 1914</u> At <u>H. G. Joannan</u> REGISTRAR		20 UNDERTAKER <u>W. C. Jackson</u> ADDRESS <u>Blythedale</u>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cook* *wife*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hausekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchomnmonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Alæmala" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Recober wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 6 1914

BUREAU

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1 PLACE OF DEATH  
County Cecil

8890

Village or City Rising Sun, Md. (No.)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91St.      Ward     

If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lydia Elmira Reynolds

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WOOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH August 13, 1838  
(Month) (Day) (Year)

7 AGE 76 yrs. 1 mos. 4 ds. If LESS than  
1 day,        hrs.  
OR        min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) Residence

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF FATHER John Lincoln

11 BIRTHPLACE OF FATHER  
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Francina J. Reynolds

13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Lizzie R. Brown

(Address) Nottingham, Pa.

15 Filed      19     REGISTRAR     

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 18, 191      
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 191     to Sept 18, 191    

that I last saw her alive on Sept. 17, 191    

and that death occurred on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH\*, was as follows:

Acute Peritonitis, caused by block in abdomen from falling down stairs.

(Duration)        yrs.        mos. 9 ds.

Contributory (Secondary) Exhaustion

(Duration)        yrs.        mos.        ds.

(Signed) Ernest Rowland, M. D.

Sept. 19, 191     (Address) Liberty House, Md.

\* State the DISEASE CAUSING DEATH, or, if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 15 yrs.        mos.        ds. in the State 15 yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rising Sun, Md.

19 PLACE OF BURIAL OR REMOVAL W. Nottingham Friends Cemetery DATE OF BURIAL SEP. 21, 191    

20 UNDERTAKER Taylor and Hirzel ADDRESS Rising Sun, Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

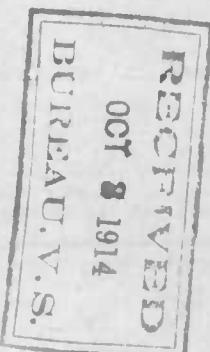
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmama*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Epidemic cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcin-*

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oma, Sarcoma, etc., of \_\_\_\_\_ (name origin; "Cap-  
er" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary). 10 d. Never report mere symptoms or terminal conditions, such as "As-  
thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenita," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "TUBERCULAR SCROTICHAC-  
MIA," "TUBERCULAR PERITONITIS," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributor." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

8891

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 93

St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City County House (No.)

2 FULL NAME Susan Rigs

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female White

4 COLOR OR RACE  
Single, married  
5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

## 6 DATE OF BIRTH

No information,  
(Month) (Day) (Year)

## 7 AGE

69 yrs. mos. ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

## 9 BIRTHPLACE

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Janus Hartnett

(Address)

Bilds Md

## 15

Filed Sept 3rd 1914 E. F. Bright  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

September 2, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1914, to Sept. 2, 1914,

that I last saw her alive on Aug. 24, 1914, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH\* was as follows:

Cancer of uterus and secondary cancer of liver

(Duration) Not known

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) M. A. Morrison, M. D.  
Sept 3, 1914 (Address) Elkton, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Cherry Hill Rd Sept 4, 1914

## DATE OF BURIAL

20 UNDERTAKER

## ADDRESS

L. A. Bennett Cherry Hill Rd

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocer*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croupy"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

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oma, *Sarcoma*, etc, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrotis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <i>Cecil</i>		8892	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <i>Principio Furnace</i>		154	Registration Dist. No. <i>96</i>	
2 FULL NAME <i>Mrs Lencia Rutter</i>		St. _____ Ward _____	[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Widowed</i>	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH <i>Aug 11, 1828</i>		16 DATE OF DEATH <i>Sept 24, 1914</i>		
		(Month) <i>Sept</i> (Day) <i>24</i> (Year) <i>1914</i>		
7 AGE <i>86 yrs 9 mos 13 ds.</i>	17 I HEREBY CERTIFY, That I attended deceased from <i>1914</i> to <i>1914</i> , that I last saw <i>her</i> alive on <i>Sept 28, 1914</i> , and that death occurred on the date stated above, at <i>1 p.m.</i> The CAUSE OF DEATH* was as follows: <i>Infirmities of old age</i>			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Housekeeping</i>		(Duration) <i>Yrs. mos. ds.</i>		
9 BIRTHPLACE (State or country) <i>Cecil Co Md</i>		Contributory Secondary		
10 NAME OF FATHER <i>Philip Craig</i>		(Duration) <i>Yrs. mos. ds.</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Cecil Co Md</i>		(Signed) <i>The W. Jackson</i> M. D. <i>Sept 26, 1914</i> (Address) <i>Principio Furnace</i>		
12 MAIDEN NAME OF MOTHER <i>Annie E Lee</i>		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.		
13 BIRTHPLACE OF MOTHER (State or country) <i>Unknown</i>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Laura Rutter</i>		At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.		
(Address) <i>Principio Furnace</i>		Where was disease contracted, If not at place of death?		
15 Filed <i>Sept, 1914</i> by <i>J. P. Lawrence</i>		Former or usual residence _____		
REGISTRAR <i>W. C. Jackson</i>		19 PLACE OF BURIAL OR REMOVAL <i>Principio Furnace Cemetery</i> DATE OF BURIAL <i>Sept 26, 1914</i>		
20 UNDERTAKER <i>W. C. Jackson</i>		ADDRESS <i>Blythdale</i>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

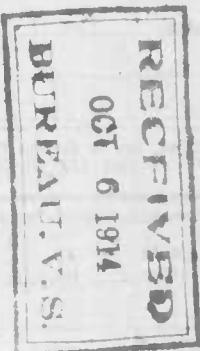
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Cancer*,

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil 91

8893

Village or City Port Deposit (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Madeline Scott

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Black

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 12, 1912

(Month) (Day) (Year)

7 AGE

2 yrs. 2 mos. 10 ds.

If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

None

## 9 BIRTHPLACE

(State or country)

Port Deposit, Md

## PARENTS

## 10 NAME OF FATHER

Philip Scott

## 11 BIRTHPLACE OF FATHER

(State or country)

Port Deposit

## 12 MAIDEN NAME OF MOTHER

Hannah Black

## 13 BIRTHPLACE OF MOTHER

(State or country)

Cecil Co

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hannah Scott

(Address)

Port Deposit

## 15

Filed Sept. 22, 1914 J. R. Cannon

Port Deposit REGISTRAR

X  
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 22, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 14, 1914, to Sept 21, 1914

that I last saw her alive on Sept 21, 1914

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

Bronchitis - Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory  
Secondary

(Duration) yrs. mos. 7 ds.

(Signed) J. R. Cannon M.D.  
Sept 22, 1914 (Address) Port Deposit, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Bethel Cemetery Sept 24, 1914

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

J. R. Cannon by Amy H. Grace

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coat maker, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic catarrhal heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1911

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 8894  
County Cecil

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92Village or City Elkton Union Hospital

(No.)

St. \_\_\_\_\_ Ward)

2 FULL NAME Gerald F Scoville

If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Sing &amp;</u>
----------------	------------------------------	--

6 DATE OF BIRTH July 10(Month) (Day) 1885 (Year)

7 AGE <u>29</u>	8 yrs <u>8</u> mos. <u>0</u> ds.	9 If LESS than 1 day,.....hrs. OR min. ?
-----------------	----------------------------------	--

10 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Dentist</u>	11 BIRTHPLACE (State or country) <u>Ohio</u>
---	---

12 MAIDEN NAME OF MOTHER <u>Mary Fulton</u>	13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u>
--	--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John S. Scoville</u>	15 (Address) <u>Phila Pa</u>
---	------------------------------

16 Filed <u>Sept 11, 1914</u>	17 Frank Fraser
-------------------------------	-----------------

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 10  
(Month) (Day) 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Sept 11, 1914, to Sept 10, 1914,  
that I last saw him alive on Sept 10, 1914,  
and that death occurred on the date stated above, at 530 P.M.  
The CAUSE OF DEATH\* was as follows:

Pneumonia - Intestinal Cholera  
(Duration) yrs. 0 mos. 0 ds.  
Contributory Syphilitic Secondary for relief of  
sore (Duration) yrs. mos. ds.

(Signed) W. L. Landwehr, M. D.  
Sept 10, 1914 (Address) Balt., Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death? \_\_\_\_\_

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Phila Pa DATE OF BURIAL Sept 14, 1914

20 UNDERTAKER Vinsinger Pippin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Macter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 6 1914

BUREAU OF THE CENSUS

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County..... *Cecil* 8895  
Village or City..... *North East* (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *94*

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Jesse H. Snipes*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) *Married*

6 DATE OF BIRTH *July 25*, 1888  
(Month) (Day) (Year)

7 AGE *56 yrs. 2 mos. 0 ds.* If LESS than  
1 day, ... hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or  
particular kind of work *Clerk*  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) .....

9 BIRTHPLACE  
(State or country) *Cecil County*10 NAME OF  
FATHER *John W. Snipes*11 BIRTHPLACE  
OF FATHER  
(State or country) *Cecil County*12 MAIDEN NAME  
OF MOTHER *Mary A. Boucher*13 BIRTHPLACE  
OF MOTHER  
(State or country) *Maryland Pa.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clara R. Snipes*(Address) *North East Md.*

## 15

Filed *Sept 5, 1914* Deaf Biddle

Locals

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 3, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
*May 27, 1914* to *Sept 3, 1914*,  
that I last saw him alive on *Sept 3, 1914*,  
and that death occurred on the date stated above, at *9 a.m.*  
The CAUSE OF DEATH\* was as follows:

*Pneumonia of Intestines*

(Duration) yrs. mos. ds.  
Contributory (Secondary) *Pulmonary* *Edema*

(Duration) yrs. mos. ds.  
(Signed) *W. L. Snipes*, M. D.  
*Sept 3, 1914* (Address) *North East Md.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

*Union Cemetery* DATE OF BURIAL  
*September, 1914*

## 20 UNDERTAKER

*H. M. Pierson* ADDRESS  
*North East Md.*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

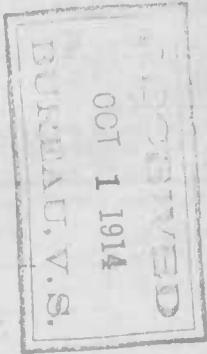
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write None.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.. Carcin-

oma, Sarcoma, etc., of \_\_\_\_\_ (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "An-  
thema," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-  
nus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Tubercular septicemia," "Tubercular peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)  
If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Oceil

8896

151

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Harrisville (No. ,)2 FULL NAME David Snyder

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

August 30, 1914  
(Month) (Day) (Year)

7 AGE

yrs. 1 mos. 19 ds. 19 If LESS than  
1 day, hrs. OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)MarylandA. W. Snyder

## PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)Elizabeth HarveyMaryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Harrisville Md

15

Filed

1914

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1914 to Sept. 11, 1914, that I last saw him alive on Sept. 17, 1914,

and that death occurred on the date stated above, at 4 a.m., The CAUSE OF DEATH\* was as follows:

Stomach ulcer(Duration) yrs. mos. 3 ds.Contributory Constitutional weakness  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Steen, M. D.  
Sept. 18, 1914 (Address) Rising Sun

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

West Nottingham Pres. Ch.

DATE OF BURIAL

Sept. 19, 1914

20 UNDERTAKER

Taylor & Horzel

ADDRESS

Rising Sun

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*oma, *Sarcoma*, etc. of \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara- nus," "Old Age," "Shock," "Truema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Postpartal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 3 1914

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		8897
Village or City <u>Terryville</u> (No.)		(169)
2 FULL NAME <u>Ernest Leonard Stark</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Sept - 30</u> (Month) (Day) (Year) <u>1894</u>		
7 AGE <u>19 yrs 11 mos 23 ds.</u>	If LESS than 1 day.....hrs. OR min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Apprentice -</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Wilmington, Del</u>		
10 NAME OF FATHER <u>Charles H. Stark</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Del -</u>		
12 MAIDEN NAME OF MOTHER <u>Ella Coverdale</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Del -</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas N Stark</u> (Address) <u>1013 Monroe St Wilmington Del</u>		
15 Filed <u>Sept 2 1914</u> Death Bedside Local		

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 94

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 1  
(Month) (Day) (Year)  
1914

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on 1914, to 1914,and that death occurred on the date stated above, at m.The CAUSE OF DEATH\* was as follows: Accidental  
Drowning

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Wm P. Dean Coroner  
Sept 1, 1914 (Address) Baltimore Md\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL  
Wilmington Del DAY OF BURIAL  
9/3 191420 UNDERTAKER  
James J. Chaudhury ADDRESS  
W. Del

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

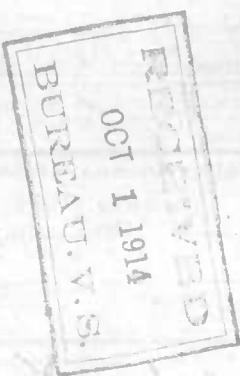
**Statement of cause of death**—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma

"car" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastos*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ocidental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8898

County BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92Village or City Providence (No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Walker D. Thompson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
-------------------	------------------------------	--

## 6 DATE OF BIRTH

Dec 17, 1859  
(Month) (Day) (Year)

7 AGE <u>54</u>	<u>55</u> yrs	<u>9</u> mos	<u>1</u> ds	IF LESS than 1 day, .... hrs. OR min. ?
-----------------	---------------	--------------	-------------	---

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Carpenter
- (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Md10 NAME OF FATHER John Thompson11 BIRTHPLACE OF FATHER  
(State or country) Md12 MAIDEN NAME OF MOTHER James Anderson13 BIRTHPLACE OF MOTHER  
(State or country) Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur WillisAddress Providence MdFiled Sept 21, 1914 J. Frank Fraser

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 18  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1914 to Sept. 18, 1914,  
that I last saw him alive on Sept 18, 1914,  
and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Sclerosis(Duration) 6 yrs. 0 mos. 0 ds.Contributory Arteriosclerosis  
Secondary(Duration) yes mos ds(Signed) Arthur Matchee, M.D.  
Sept 18, 1914 (Address) Tidemont Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?Former or  
usual residence \_\_\_\_\_19 PLACE OF BURIAL OR REMOVAL Henry Heil DATE OF BURIAL Sept 22, 191420 UNDERTAKER P. C. Wilson ADDRESS Newark Del

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Muager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc, of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report were symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congeulat"), "Scluse," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 9 1914

BUREAU, U. S. A.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County		8899 <i>Cecil Pleasant Hill (51)</i>	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City		(No.) <i>Savordown</i>	Registration Dist. No. <i>92</i>	St. Ward [If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME		<i>John Francis only lived 5 minutes</i>		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word)	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH <i>Sept 21</i>		(Month) (Day) (Year) <i>1914</i>	16 DATE OF DEATH <i>Sept 21st</i>	(Month) (Day) (Year) <i>1914</i>
7 AGE <i>Lived 5 minutes</i>	yrs. <i>0</i>	mos. <i>0</i>	ds. <i>0</i>	OR min. ? <i>5</i>
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>None</i>		If LESS than 1 day, .... hrs. OR min. ? <i>0</i>		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>None</i>		Duration (Duration) yrs. mos. ds. <i>None</i>		
9 BIRTHPLACE (State or country) <i>Pleasant Hill Ma</i>		Contributory Secondary <i>Impaired closure of</i> <i>obstruction</i> (Duration) yrs. mos. ds. <i>None</i>		
PARENTS		10 NAME OF FATHER <i>Jos L Thompson</i>		
		11 BIRTHPLACE OF FATHER (State or country) <i>Elkton Ma</i>		
		12 MAIDEN NAME OF MOTHER <i>Emmale Marcus</i>		
		13 BIRTHPLACE OF MOTHER (State or country) <i>Elkton Ma</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Joseph S Thompson</i> (Address) <i>Wmll East</i>				
15 Filed <i>Sept 21st 1914</i>				
REGISTRAR			DATE OF BURIAL <i>Sept 22, 1914</i>	
UNDERTAKER <i>Jos L Thompson</i>			ADDRESS <i>Goodman</i> <i>Wmll East Rd</i>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V.A. 111

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day Laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma

oma

oma, Sarcoma, etc., of..... (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malig-  
nant neoplasms); *Mastitis*; *Whooping cough*; *Chronic  
valvular heart disease*; *Chronic interstitial nephritis*,  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Ex-  
ample: *Measles* (disease causing death), 29 d.;  
*Bronchopneumonia* (secondary), 10 d. Never report  
mere symptoms or terminal conditions, such as "As-  
thenia," "Anaemia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Uraemia," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage as "PUERPERAL septicæ-  
mia," "PUERPERAL peritonitis," etc. State cause for  
which surgical operation was undertaken. For viol-  
ENT DEATHS state MEANS OF INJURY and qualify as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*  
such, if impossible to determine definitely. Examples:  
*Accidental drowning*; *Struck by railway train—acci-  
dental*; *Revolver wound of head—homicide*; *Poisoned  
by carbolic acid—probably suicide*. The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
*sensus, tetanus*) may be stated under the head of  
"Contributory." (Recommendations on statement of  
cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-  
tions answered in detail, it will prevent further correspond-  
ence. All the data is essential and must be obtained before  
the certificate is permanently filed.



OCT 6 1914

## MARGIN RESERVED FOR BINDING

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V. S. No. 1.

<sup>1</sup> PLACE OF DEATH County <u>Baltimore</u>		8900	175
Village or City <u>Reservoir</u>		<u>Unknown</u>	
<sup>2</sup> FULL NAME <u>Unknown</u>			
PERSONAL AND STATISTICAL PARTICULARS			
<sup>3</sup> SEX <u>Male</u>	<sup>4</sup> COLOR OR RACE <u>White</u>	<sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>No information</u> (Write the word)	
<sup>6</sup> DATE OF BIRTH <u>No information</u>		(Month) <u>1</u>	(Day) <u>1</u>
		(Year) <u>1914</u>	
<sup>7</sup> AGE <u>No information</u>		IT LESS THAN 1 day, <u>hrs.</u> OR <u>min. ?</u>	
YRS. <u>0</u>	MOS. <u>0</u>	DS. <u>0</u>	
<sup>8</sup> OCCUPATION (a) Trade, profession, or particular kind of work. <u>No information</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>			
<sup>9</sup> BIRTHPLACE (State or country) <u>No information</u>			
<sup>10</sup> NAME OF FATHER <u>Wm P Dean</u>			
<sup>11</sup> BIRTHPLACE OF FATHER (State or country) <u>No information</u>			
<sup>12</sup> MAIDEN NAME OF MOTHER <u>No information</u>			
<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) <u>No information</u>			
<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm P Dean</u>			
(Address) <u>Elkton</u>			
15	Filed <u>Apr 23</u> , 1914		Trans. <u>Frank Frayer</u>
		REGISTRAR	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Sept 22, 1914  
(Month) Sept (Day) 22 (Year) 1914

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h. alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Came to death by being struck by a car road train on B & O R.R. Accidental

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Wm P Dean (Address) Elkton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Blue House DATE OF BURIAL Sept 23 1914

<sup>20</sup> UNDERTAKER Daniels & Son

ADDRESS Elkton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis*; *Whooping cough*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
OCT 6 1914
REG. U. S. S.



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
OCT 6 1914
U. S. DEPT. OF COMMERCE

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
Cecil Co.  
County.....

8902

79

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 90

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Cecilton (No.)

## 2 FULL NAME

Walker Washington

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Shdowner
------------	-------------------------	--

## 6 DATE OF BIRTH

8 7, 1847  
(Month) (Day) (Year)

## 7 AGE

66 yrs. 10 mos. 25 ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Farm Labourer

Essix Co. Va.

## PARENTS

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER  
(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER  
(State or country)

Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Washington

(Address)

Cecilton Ind.

## 15

Filed Sept 1, 1914

J. H. Black Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

9 3

(Month)

(Day)

, 1914  
(Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1914, to Sep 3, 1914,

that I last saw him alive on Sep 3, 1914,

and that death occurred on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH was as follows:

Chronic Paroxysmal Agitato.

(Duration) 4 yrs. — mos. — ds.

Contributory  
Secondary

Nervous Regurgitation

(Duration) 3 yrs. — mos. — ds.

(Signed)

R. McDowell M. D.

Sep 4, 1914 (Address) Newark Ind.

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Polar Neck Cem. - self 5, 1914

## 20 UNDERTAKER

John F. Coffey Cecilton Ind.

## DATE OF BURIAL

## ADDRESS

**REVISED UNITED STATES STANDARD**

CERTIFICATE OF DEATH

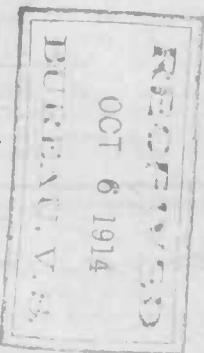
Approved by U. S. Census and American Public Health Association

ASSOCIATION

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coatmine*, etc. Women at home, who are engaged in duties of the household only (not paid *Housekeepers*), who receive a definite salary, may be entered as *Housewife*, *Housework*, or *At Home*, and children, notably gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Jaænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.





# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

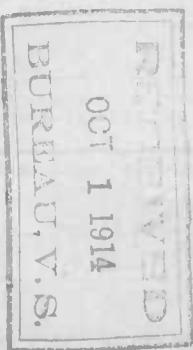
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

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oma

*Sarcoma*, etc. of \_\_\_\_\_ (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Miasma," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Tuerperal septicemia*," "*Tuerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
Cecil 8904

County.....

Village or City Charleston (No.)

(52)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Webber (m-f-Elie)

Triplet no 2

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	white	Single

6 DATE OF BIRTH  
Sept 26, 1914  
(Month) (Day) (Year)

7 AGE  
0 yrs. 0 mos. 3 ds.  
It LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work...
- (b) General nature of industry, business, or establishment in which employed (or employer) ...

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  
W. C. Campbell(Address)  
W. C. Campbell

15 Filed Sept 26, 1914, at Biddle Local

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Sept 26, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1914, to Sept 26, 1914, that I last saw him alive on Sept 25, 1914, and that death occurred on the date stated above, at 3 a.m.,

The CAUSE OF DEATH\* was as follows:

Congenital Atelectasis

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Signed) W. C. Campbell, M. D.

Sept 26, 1914. (Address) W. C. Campbell

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
It not at place of death?Former or  
usual residence...

19 PLACE OF BURIAL OR REMOVAL

Cathedral, Md. Sept 26, 1914

20 UNDERTAKER

John Graham, Charlestown

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma

"Sarcoma, etc. of \_\_\_\_\_" (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Athetia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Taenia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Postpartal septicæmia*," "*Postpartal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver round of had—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasms*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH County <u>Cecil</u>		8905	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Port Deposit</u> (No. <u>104</u> )		St.; Ward)	Registration Dist. No. <u>96</u>	
2 FULL NAME <u>Genevieve A Will</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	MEDICAL CERTIFICATE OF DEATH	
6 DATE OF BIRTH <u>July 14</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Sept 7</u> (Month) (Day) (Year)		
7 AGE <u>1 yrs. 21 mos. 21 ds.</u>		17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 27</u> , 1914, to <u>Sept 7</u> , 1914, that I last saw <u>her</u> alive on <u>Sept 7</u> , 1914, and that death occurred on the date stated above, at <u>6pm</u> .		
8 OCCUPATION (a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer) <u>Infant</u>		The CAUSE OF DEATH* was as follows: <u>Auto Soditis</u>		
9 BIRTHPLACE (State or country) <u>Port Deposit Md</u>		(Duration) yrs. <u>4</u> mos. <u>4</u> ds.		
10 NAME OF FATHER <u>Matthew Will</u>		Contributory <u>malnutrition</u> Secondary		
11 BIRTHPLACE OF FATHER (State or country) <u>Cecil Co Md</u>		(Duration) yrs. <u>1</u> mos. <u>1</u> ds.		
12 MAIDEN NAME OF MOTHER <u>Pauline Brauer</u>		(Signed) <u>G. J. Benson</u> M. D. (Address) <u>Port Deposit Md</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Port Deposit Md</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Matthew Will</u> (Address) <u>Port Deposit</u>				
15 Filed <u>Sept 8 1914</u> St. P. Brauer REGISTRAR		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence: _____		
16		19 PLACE OF BURIAL OR REMOVAL <u>West Nottingham Cemetery</u> Sept 9, 1914 20 UNDERTAKER <u>J. C. Jackson</u> ADDRESS <u>Blythedale</u>		
If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.				

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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OCT 6 1914

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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8906

**1 PLACE OF DEATH**

County Cecil

Village or City Calvert (No. 10)

**2 FULL NAME** Baby Gerkes

PERSONAL AND STATISTICAL PARTICULARS				
<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b>	<b>6</b>	
<u>Male</u>	<u>White</u>	<u>Single</u>		
<b>7 DATE OF BIRTH</b>		<b>8 AGE</b>	<b>9 OCCUPATION</b>	
<u>Sept.</u> <u>13</u> , <u>1914</u>		<u>10 yrs.</u> <u>10 mos.</u> <u>10 ds.</u>	(a) Trade, profession, or particular kind of work <u>No</u>	
			(b) General nature of industry, business, or establishment in which employed (or employer) <u>No</u>	
<b>10 NAME OF FATHER</b>		<b>11 BIRTHPLACE OF FATHER</b>		<b>12 MAIDEN NAME OF MOTHER</b>
<u>Willie L. Gerkes</u>		<u>Chester Co., Pa.</u>		<u>Mira K. Kimble</u>
<b>13 BIRTHPLACE OF MOTHER</b>		<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>		
<u>Chester Co., Pa.</u>		(Informant) <u>Calvert</u> (Address) <u>North Side Rd.</u>		
15		16		
Filed <u>101</u> by <u>L. M. Nottingham</u>		Registration No. <u>91</u>		

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 13<sup>rd</sup>, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Starve to m.

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. T. Remm, M. D.Sep. 14<sup>th</sup>, 1914 (Address) Office Remm

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rosebank Md Sept. 14, 1914

20 UNDERTAKER ADDRESS

B. E. Mason Nottingham

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*oma, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for violent deaths state means of injury and quality as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**  
OCT 3 1914  
BUREAU, U. S. A.